

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04950 DECEASED-NAME (Type or print) MERVIN		First LEE	Middle BLADES	Last BLADES	2a. DATE OF DEATH Month March Day 7 Year 1968		2b. HOUR 1:00 M
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 26, 1910		6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Worcester Md.	
10. CITY OR TOWN OF DEATH Pocomoke City		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 204 11th Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Contractor		12b. KIND OF BUSINESS OR INDUSTRY General Building	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 204 11th Street		14. FATHER'S NAME First Alonzo Middle L. Last Blades		15. MOTHER'S MAIDEN NAME First Anna Middle Webb Last Webb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) --		16b. SOCIAL SECURITY NO. 213-05-2004		17. INFORMANT Address Mrs Dolores Blades, Pocomoke City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, Massive 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 12 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Mar. 26 , 19 68 , to Mar. 7 , 19 68 , that (I) (we) lost saw the deceased alive on Mar. 7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles W. Trader M.D.		22c. DATE SIGNED 3-4-68		22d. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D., 302 Market St. Pocomoke, Md.		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-3-1968		23c. NAME OF CEMETERY OR CREMATOR First Baptist		23d. LOCATION (City or Town) (County) (State) Pocomoke City - Wor.-Md.	
24. FUNERAL DIRECTOR Robert H. Watson		25a. REC'D BY REGISTRAR Robert H. Watson		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 5 1968	

IN SENATE,

January 1, 1870.

REPORT

OF THE

COMMISSIONERS OF THE LANDS,

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE,

AT ITS SESSION, APRIL 1, 1869.

BOSTON:

WILLIAM D. LANE, PRINTER.

1870.

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CERTIFICATE OF DEATH

04952

04952

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Amelia		H.		Donoway	March 3 1968		6:00 PM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female	White		Oct. 23, 1874		93 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Delaware		USA				Worcester Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Whaleyville		Home		Housewife		Own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Worcester		Whaleyville				RED	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Lost		First Middle Lost							
Mitchell		Donoway		Mary Ellen Parker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
XX		XX		xx Claude Donoway Whaleyville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary aorta</u>								6 yrs	
582X DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								Chr Brights	
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
592X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1948</u> to <u>3-3-1968</u> , that (I) (we) last saw the deceased alive on <u>3-3-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>Charles R. Law</u>						3-5-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
CHARLES R. LAW		Berlin Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/6/68		Dale		Whaleyville Worcester Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Peter Whaley		Whaleyville, Del.		DATE MAR 8 1968		Charles Jones			

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Item 5 Film G398 3/11/68 kk

CERTIFICATE OF DEATH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04953

1. DECEASED-NAME (Type or print) ETHEL FRANCIS EVANS			20. DATE OF DEATH Month March Day 1 Year 1968			2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH Aug. 11, 1908		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Worcester Md.
10. CITY OR TOWN OF DEATH Snow Hill		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 204 E. Federal St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Thomas Middle Williams Last Williams		15. MOTHER'S MAIDEN NAME First Ida Middle B. Last Butler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. 213-42-1142		17. INFORMANT Address Mr. C. T. Evans, Princess Anne, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma (source undetermined) DUE TO, OR AS A CONSEQUENCE OF (c) 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 1991						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic heart disease, Pulmonary emphysema, Chronic nephritis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Sept , 19 66 , to 3-1-68 , 19 68 , that (I) (we) last saw the deceased alive on 2-27-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Robert La Mar MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-4-68
22d. PHYSICIAN'S NAME (Type) Robert La Mar MD		22e. ADDRESS Snow Hill, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/4/1968		23c. NAME OF CEMETERY OR CREMATORY Bates Methodist Cem.		23d. LOCATION (City or Town) (County) (State) Snow Hill, Wor. Md.
24. FUNERAL DIRECTOR Donald C. Saunders		ADDRESS Snow Hill, Md.		25a. REC'D BY REGISTRAR MAR 7 1968		25b. REGISTRAR'S SIGNATURE John Judge

status

status

(continued) (continued)

Psychological tests, physical tests, chronic health

DO 1-1-75

1-1-75

MAR 7 1975

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

MEDICAL CERTIFICATION

04953				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04954					
1. DECEASED-NAME (Type or print)				First	Middle	Lost	2a. DATE OF DEATH Month Day Year				2b. HOUR M		
Sarah						Foeman	Mar. 3 1968						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
Female		Negro		Feb. 23, 1916			32 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH				Md.	
Md.		U.S.A.						Worcester					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Stockton						Laborer			Factory				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
Md.			Worcester		Stockton				Bx. 138				
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost		
Unknown						Ellen					Terpin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
No						James Foeman			Stockton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT.</u> <u>412.0</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARDIO-VASCULAR SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERCHOLESTIMIA</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
											UNDETERM.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>440X HYPERTENSION</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/8</u> , 19 <u>66</u> , to <u>3/3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <u>Neville A. Baron</u>						22c. DATE SIGNED <u>3/4/68</u>							
22d. PHYSICIAN'S NAME (Type) <u>NEVILLE A. BARON</u>						22e. ADDRESS <u>POCOMOTE, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
Burial		3-9-68		Foeman Cem.		Stockton		Wor.		Md.			
24. FUNERAL DIRECTOR <u>James L. Lavelle</u>						25a. REC'D BY REGISTRAR DATE <u>MAR 7 1968</u>		25b. REGISTRAR'S SIGNATURE <u>James L. Lavelle</u>					

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

He

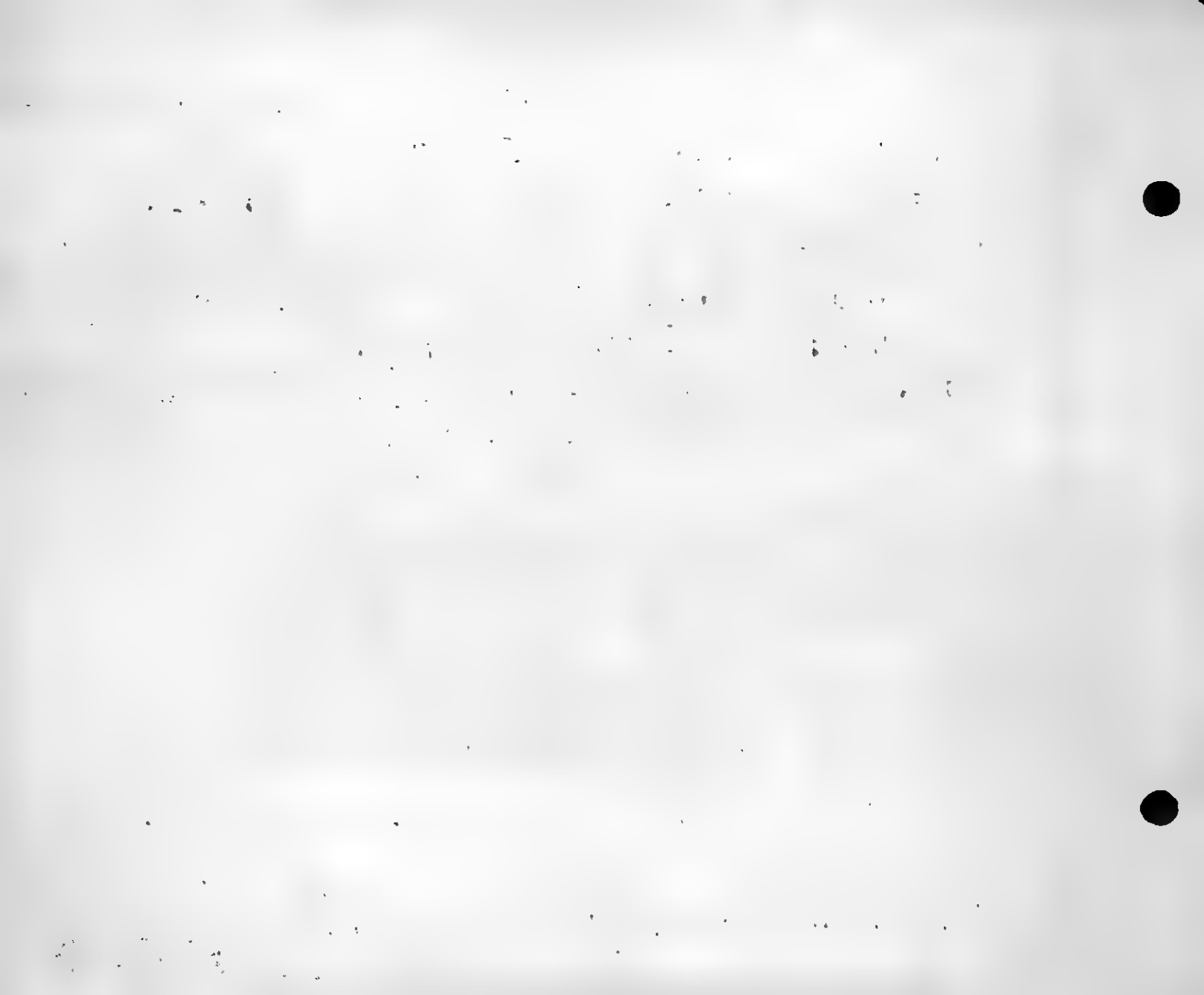
VR A15ME (5)
10M REV. 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Page 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>George C. James</u>			2a. DATE OF DEATH Month <u>Mar.</u> Day <u>28</u> Year <u>1968</u>			2b. HOUR <u>6:30 P.M.</u>		
3. SEX <u>Male</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH <u>June 21, 1892</u>		6. AGE (In years last birthday) <u>75</u> YRS	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>	IF UNDER 24 HRS. HOURS <u> </u> MIN <u> </u>
7a. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Worcester</u> Md.		
10. CITY OR TOWN OF DEATH <u>Pocomoke</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>R.F.D.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Laborer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Worcester</u>		13c. CITY OR TOWN <u>Pocomoke</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <u>R.F.D. 2, Box 312</u>		14. FATHER'S NAME First <u>William</u> Middle <u>James</u> Last <u>James</u>		15. MOTHER'S MAIDEN NAME First <u>Sarah</u> Middle <u> </u> Last <u> </u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>163-18-2665</u>		17. INFORMANT <u>Maggie James R.F.D. 2 Pocomoke, Md.</u>		Address <u> </u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>337 x</u> (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF <u> </u> (c) <u> </u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u> </u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Death known - Only seen from outside and in a comatose condition</u>								
19a. DATE OF OPERATION <u>No operation</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u> P.M. <u> </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u> </u>		21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>				
22a. I certify that (I) (this hospital) attended the deceased from <u>March 25, 1968, to March 21, 1968</u> , that (I) (we) lost saw the deceased alive on <u>March 25, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>N.E. Sartorius M.D.</u>		22c. DATE SIGNED <u>3/24/68</u>		22d. PHYSICIAN'S NAME (Type) <u>N.E. SARTORIUS</u>				
22e. ADDRESS <u>POCOMOKE CITY</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Apr. 2, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hall's Hill Cem.</u>		
23d. LOCATION (City or Town) (County) (State) <u>Pocomoke Wor. Md.</u>		24. FUNERAL DIRECTOR <u>Samuel Lewis</u>		25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
25c. ADDRESS <u>New Church Va.</u>		25d. DATE <u>APR 1 1968</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
CHARLIE S. PILCHARD					March 1, 1968		7:30 P.M.		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male	White		March 20, 1875		92 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U. S. A.				Worcester Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Berlin		Berlin Nursing Home		Carpenter (Ret.)		Cabinet			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Worcester		Girdletree					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Dennard W. Pilchard		Cora A. Brittingham							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No		230-32-0721		Mr. M. Elwood Watson, Berlin, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocarditis</u> <u>428X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Myocarditis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute coronary</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>422.1</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
				22a. I certify that (I) (this hospital) attended the deceased from <u>4-1-68</u> , to <u>3-1-68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-1-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Clifford E. Schott MD</u>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
				Clifford Schott, MD					
22e. ADDRESS		22f. ADDRESS							
		Berlin, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Mar. 4, 1968		Baptist Cemetery		Girdletree, Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Gerald C. Brown		DATE MAR 7 1968		Charles Judge					

THIS CERTIFICATE IS TO CERTIFY THAT
the within and foregoing is a true and correct
copy of the original as the same appears
from the records of the County Clerk of
this County, Texas, in and to which
the same has been duly recorded.

WITNESSED my hand and the seal of said
County, this _____ day of _____
A.D. 19____.

County Clerk

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) Peggy Irene Purnell		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MAR 4 1968		2b. HOUR 11:20 P.M.
3. SEX F	4. RACE N	5. DATE OF BIRTH Sept 13 1946	6. AGE (In years last birthday) 21 YRS.	2c. DATE PRONOUNCED DEAD Month 19 Day 19 Year 19
7a. BIRTHPLACE (State or foreign country) Shawell, Md		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Worcester		10. CITY OR TOWN OF DEATH Rural-Bishopville		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route 1		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework		12b. KIND OF BUSINESS OR INDUSTRY —
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY WOR	13c. CITY OR TOWN Bishopville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME Moses — Purnell		15. MOTHER'S MAIDEN NAME Margie Mumford		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
16b. SOCIAL SECURITY NO. 219-44-1788		17. INFORMANT Mrs. Margie Purnell R Bishopville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUN SHOT WOUND head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 965X (c) INSTANT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH INSTANT
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 981X				
19a. DATE OF OPERATION 3/4 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Shot in head		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 3/4 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot in head
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State R1 Bishopville, Md WOR
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE F.J. Townsend, Jr		CHIEF MEDICAL EXAMINER F.J. Townsend, Jr MD		22b. DATE SIGNED MAR 5 1968
EXAMINER'S NAME (Type) F.J. Townsend, Jr		DEPUTY MEDICAL EXAMINER Richard T. Watson		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 3/9/68		23c. NAME OF CEMETERY OR CREMATORY Dukes Cem.		23d. LOCATION (City or Town) (County) (State) Bishop, Wor. Maryland
24. FUNERAL DIRECTOR Richard T. Watson		ADDRESS Selbyville, Del.		25a. REC'D BY REGISTRAR Charles Judge
		DATE MAR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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